Comments and Responses on ARC 7526B

Reorganization of Group Care Contracting Rules and
Removal of References to Rehabilitative Treatment Services and Other Obsolete Provisions
Received February 20, 2009

A public hearing was held on February 20, 2009, which was attended by seven persons. The following persons and organizations provided written comments, which are included in the summary below:

Mike Arndt, chief operating officer, Youth Homes of Mid-America
Keith Gatrost, vice president of residential services, Four Oaks, Cedar Rapids
Ann Harrmann, associate director, Coalition for Family and Children's Services in Iowa
Doug Johnson, president, Coalition for Family and Children's Services in Iowa
John Kemp, quality improvement director, Four Oaks, Cedar Rapids
James Ottosen, counsel, Family Resources, Inc., Davenport
Ron Stehl, executive director, Youth Homes of Mid-America

Staffing Ratio

COMMENT: Under the previous rule, the enhanced group care staffing ratio was more flexible…the sliding scale Enhanced staff-to-client ratios [were] as follows;

1 staff for facilities serving up to 4 children
2 staff for facilities serving 5 to 7 children
3 staff for facilities serving 8 to 10 children
4 staff for facilities serving 11 to 13 children
5 staff for facilities serving 14 to 16 children
6 staff for facilities serving 17 to 19 children,
1 staff for every 3 children for facilities serving 20 or more children

As we are currently licensed, under the proposed rules, YHMA would have to add 2 additional FTE's for each of our 7 bed Enhanced cottages for a total of 12 additional staff. Without any corresponding increase in revenue our current financial situation could not withstand such a staffing increase.

The alternative would be to keep the same number of staff in each of the 7 bed Enhanced cottages and reduce by one the number of kids in each of those cottages, for a total reduction of 6 kids. The loss of revenue from six kids without a corresponding decrease in number of staff could not be supported within our current financial situation.

We would request that DHS change the enhanced group care staffing ratio to the previous 441–185.10 requirement (Stehl, Arndt)

COMMENT: The rules as amended now reflect that enhanced comprehensive care is identified by a prime time ration equivalent to that identified in the RTSS contracts—1-3 or 4, depending on the number of children present. We might suggest that the identification of an identified 'prime time,' though traditional in Iowa, is suggestive of a lesser need for other awake times which is unrealistic with needy populations.

The Council on Accreditation of Children and Family Services, rather than identifying a special 'prime time,' requires a ration of 1 to 5 at all awake time in their Residential Treatment Program standards which would be roughly equivalent to enhanced comprehensive group care. We would recommend a equivalent all day minimum with a requirement that programs have specific implemented procedures for determining when there is need for additional staff. This philosophy seems to be recognized by the provisions of proposed rule 441—152.2(b), though standing alone it would be too vague to be helpful (Otteson)

RESPONSE: In the previous RTSS program for the enhanced level group care, the Department talked about a "1 to 3" staff/client ratio. Actually the previously rescinded 185.83(3)"b" (IAB 4/11/07, effective 7/1/07) and the provider handbook, Chapter B, identified a 1 to 3.33 ratio, so the previous language was put back into the new rules in the definition for "Level of Care", item 3. Enhanced comprehensive-level group care.

Effective Date of Changes

COMMENT: Because we believe that the Department's propose rule changes are, in part, substantive in nature, we also are concerned that it appears to be the Department's intent to apply the proposed rule retroactively to November 1,2006. Obviously, it is not reasonable to retroactively impose a new rule on providers that would require a change of practice in order to comply with the new requirement. This puts providers at risk of being required to return to the Department reimbursements received for services provided and appropriately billed under the existing rule. (Kemp)

COMMENT: As a general principle, the Coalition can not support rules which are applied retroactively. Providers acting in good faith can only be held accountable for requirements that are clearly known at the time of service delivery and billing. (Harrmann)

COMMENT: The Coalition has no objection to formalizing [the daily log] as a requirement for reimbursement going forward. However, it appears that the proposed rule would be applied retroactively to November 1, 2006. This would be both unreasonable and unfair since it could require providers to return payment for services that have been provided and were appropriately billed under the rule in existence at the time of billing.

It is worth noting that changes in required documentation to support claims for reimbursement should never be made retroactively. Providers, acting in good faith, can only be held accountable for documentation requirements that are clearly known at the time of service delivery and billing. (Johnson)

RESPONSE: The Department's intention is not to make these proposed rules retroactive. The reference to the November 1, 2006, date was solely a reference to delinking the rehabilitative treatment method of payment that the Department had in place for group care from the child welfare method the Department presently has for group care. The Department is aware that the rules become effective after they are adopted. The expected effective date of these rules is July 1, 2009.

Service Documentation: Daily Logs

COMMENT: A specific provision that concerns us is proposed section 152.2(6) (a), which would contractually require providers to maintain a "daily log." Currently, maintenance of a daily log is a licensing requirement for foster group care facilities but has not previously been required documentation to support an agency's claim for reimbursement of child welfare services and group care maintenance. This requirement is a specific example of our concern about the intended retroactive application of the proposed rule. But, in addition to the retroactive application of a rule, we are also concerned that this proposed section codifies the Department's recent practice of considering the daily log as the only acceptable document supporting a provider's claim for services rendered. Four Oaks and other providers of group care services maintain contemporaneous documentation of services rendered to a client in a number of different formats as staff routinely documents interactions with a client.

Our other primary concern, given the previously proposed retroactive effective date, was the use of the daily log as the underlying documentation for billing purposes. If changes are made prospectively, as now proposed, this concern is greatly diminished. We appreciate that the Department defines expected documentation for billing purposes in terms of expected content rather than being prescriptive of a particular document or format. This permits providers to more effectively integrate the documentation with other records providers maintain to track and manage a child's care. (Kemp, Gatrost)

COMMENT: The proposed section 152.2(6)(a) would contractually require providers to maintain a "daily log". This contractual requirement could then be understood by the Department as required documentation for reimbursement of child welfare services and group care maintenance. It is common for group foster care providers to maintain contemporaneous documentation of services rendered to a client in different formats, several of which, when taken together, clearly support a claim of reimbursement for services. While maintenance of a daily log is a licensing requirement for group foster care facilities, it has not, until very recently, been interpreted as required documentation in support of a claim for reimbursement. (Johnson)

COMMENT: Our suggestion is that there was nothing wrong with the concept of the 'daily log' as long as it was not made exclusive on a retroactive basis and assuming a clearer definition of what it was expected to look like. We would suggest something in between that and what is now proposed, which would be a record made daily by qualified staff describing the significant activities, events and interventions involved with the child sufficient to provide assurance that the child is receiving benefit from the kind of services described in 441 lAC 156. (Ottosen)

RESPONSE: What the Department is now proposing as part of the changes is to take out the requirement of the daily log as the ***only*** documentation for billed services. It is the Department's position that documentation for billed services does not have to be a separate stand-alone document. It could be the daily log, provided the daily log meets the documentation of billed services requirement. The Department will continue to look at the daily logs as long as they meet the requirements identified. So if providers want to keep only one record of services provided, and the daily log meets the requirements, that will be sufficient to document billed services.

The Department is not expecting any onerous types of documentation. However, if a child is having an unusual problem or behavior and a staff person makes an intervention, then the Department considers this a significant event that should be documented in the child's record. The record should include the date that the problem or behavior happened, what the intervention was, the child's response, the staff response, and the name of the staff person that intervened.

Service Record

COMMENT: Another specific concern we have with the proposed rule is the definition it contains of "service record." At a time when the Department should be encouraging providers to gain whatever efficiencies are possible by using electronic client records, we are fearful that the proposed definition of "service record" could be construed to prohibit or limit a reliance on electronic client records by using the word "tangible" in defining this term. (Kemp)

COMMENT: The subject of acceptable documentation of billed service is unavoidably a pressure point because the interests are keen and to a certain extent competing. The department needs reasonable assurance that services are being provided and the provider wants assurance that their documentation will be sufficient to avoid overpayment declarations. We recognize the difficulty of crafting a regulation which meets both needs and we truly do appreciate the department's response to concerns expressed by some of us concerning the subject of 'daily logs' through the proposed amendment. We feel, however, that the importance of the subject deserves our comment which we hope will be received in the constructive spirit in which it is offered.

Unlike the previous RTSS system which involved a series of closely defined units of service required to be delivered in specific quantums daily, the service definitions for child welfare services and maintenance are quite broad. In essence they encompass almost everything that happens in a child's life while in the program-from basic hygiene to supervision, to feeding, to specific activities, to one on one and group skill sessions and so forth. To that extent, they contemplate methods of 'delivery' that are much broader in scope and more varied in nature than the previously closely defined RTSS services. We are concerned that the newly proposed requirement for documentation more closely resembles that which would be required of such a defined unit than for adequately describing the activities, programming, interventions, and events of the child's day. For example, the requirement that the first and last names of the individuals providing service be listed would require the listing of each and every staff member involved in the child's supervision throughout the day, including all shifts, medical personnel, dietary staff and so forth. The only option to avoid that would be to select services delivered by single individuals and document them as a unit of service in the manner described, but that is probably too narrow to capture the totality of the services for which compensation is sought.

We do not object, and in fact endorse, the requirement that the record contain periodic progress summaries. That is best practice as reflected by the Council on Accreditation standard for client records in Residential Treatment programs which requires a progress summary at no less than 30 day intervals and more frequently as determined by the population served. We don't think seven day intervals unreasonable for a needy population. The question has been raised, however, whether one omission of a seven day summary, or a late summary, would result in an overpayment declaration for the child for a week. That concern, of course, goes to the heart of the tension concerning service documentation. (Ottosen)

RESPONSE: In terms of having a tangible record, the Department is not taking a position on how agencies keep the service records at this time. Although, the Department prefers tangible documents, we understand may agencies have moved to electronic record keeping. When any Department personnel need to review the records, the records must be available to the reviewer. If an agency wants the Department staff to use its IT system to access the records, the agency must understand that the Department is not interested in learning the various agencies' IT programs. Assistance will need to be provided if records are to be accessed through a computer.

Typically the Department does not make a judgment on the quality of the documentation, but primarily if the documentation exists. The Department's goal is not to find ways to make providers pay back money, but to ensure that the services are documented to justify the payment.

The request was made that the Department further clarify the requirements of the documentation language. The Department intends to respond with clarifications when the release of the provider manual occurs. That is really the implementation of the rules and is how the Department has used the provider manual in the past. The Department's tentative timeline for preview of the provider manual and contract is late May. The Department intends to continue to work with providers on questions and clarifications before the July 1 implementation.

Rate Determination

COMMENT: This provision lays out a version of the rate negotiation process previously built into the RTSS contracting process. Of course, rate negotiation has been 'frozen' and has not occurred for a number of years. We will assume, however, for the purpose of comment that this provision is intended to be operative for the 'new contracts' entered into under these rules. If that is not the case, there remains the prospect of 'unfreezing' at some time in the future and issues will be applicable then as well as now. Here are the comments:

- The introductory paragraph itself gives us some concern. It references historical rates 'negotiated' at one time pursuant to chapter 185 and 'calculated' pursuant to chapter 156.9. Chapter 156.9 provides for the calculation of a straight cost based rate. In fact the rate so calculated may have formed the basis for a negotiated rate, but was not, we assume the final rate. This should be clarified .
- 152.3(1)(a) States that the previously negotiated rates under RTSS ' ... remain true and valid'. We wonder if that statement is accurate and what its effect might be. In November of 2006 the department made a division of the bundled rate fur group care based on an estimation of the amount which could thereafter be attributable to remedial services. To the extent that estimation, or the estimation of the unit cost of remedial services, proved to be incorrect, the residual rate for the residential portion of the service would not reflect actual cost. It might be higher or it might be lower. Under any circumstance, it is not based on a settled cost report. We believe the baseline for any new rate, whether negotiated or not, should be actual allowable cost. (In short, a chapter 156 calculation.)
- 152.3(1)(c) This provision is identical to one found in Chapter 185, but we remain concerned

about the wording. We assume that it is intended to make it clear that negotiations were not to involve conditions of service. However, the final phrase' .... or used as a basis for changing rates.'; if read literally means that the department is able to impose any condition of performance it deems appropriate and expect it to be provided at the existing rate, no matter the cost. We don't believe that is the intent and hope the language can be clarified ..

- 152.3(1)(h) This provision echoes the concern of the previous cited provision.

The only allowed change in a negotiated rate in a contract of six years duration is for an across the board mandated increase. The department, however, by rule may change the conditions of performance. If such a change were to increase or decrease cost, a concurrent ability on either side to renegotiate based on that cost change should be available. (Ottosen)

RESPONSE: The rates are still frozen and future rate adjustments continue to be at the discretion of the Legislature. It is the Department's intention to not do anything with rates at this time, as it is anticipated this inherited rate structure will be in place for only a few more years under this contracting arrangement. As the Department complies with the Accountable Government Act for contracting, we anticipate a different rate structure under performance-based contracting and competitive bidding under a group care request for proposals.